Clinical Documentation Improvement at UIHC

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Clinical Documentation Improvement
Clinical Documentation Improvement

• Clinical Documentation Nurses:
  – Also known as CDI Nurses
  – Help translate clinical documentation/patient hospital course into hospital coding language
    • Sending queries
    • Participate in rounds and huddles
    • Provide educational resources or LIP teaching
  – Cover all inpatient units except: NICU, inpatient psych, or Mother/Baby
Goal of CDI?

- Accurate reflection of severity of illness and intensity of service that results in appropriate MS-DRG assignment

CDI – Clinical Documentation Improvement
Limitations

Current Limitations

- Coding can only be based on MD, DO, NP, PA documentation
- Coders cannot use orders, radiology reports, lab results, medication lists, or nurse’s notes
- Documentation sufficient for clinician communication is not always adequate for coding
- Physicians shouldn’t deal with complex coding!

**Provider and CDI Must Work Together!**
Your Role in Documentation Improvement

Accurate Documentation Drives …

• Accurate reflection of patients’ Severity of Illness (SOI)

• True indication of Risk of Mortality (ROM)

• Appropriate hospital and physician public profiles

• Reduction in denials for medical necessity or reimbursement issues

• Appropriate hospital reimbursement
Supporting Documentation

For Acute Inpatients

• **Every condition** that is documented as a secondary diagnosis in problem lists or progress notes needs **supporting documentation** on how it is being:
  - Monitored
  - Evaluated
  - Treated

• **Regardless of clinical significance**—we need to document anything that’s treated, evaluated, monitored, increases LOS, or RN workload.
Your Role in Documentation Improvement

• Documentation of MCCs/CCs
  – Some secondary diagnoses impact the care given to our patients more than others and therefore impact CDI metrics for severity of illness and risk of mortality. These diagnoses are called CCs and MCCs. MCCs/CCs are drawn from the documentation of secondary diagnoses, and are not the principle diagnosis.
  – Complication/Comorbidity (CC): This is a secondary diagnosis that increases the resources we use to care for the patient. This diagnosis may increase a patient’s length of stay, too.
  – Major Complications/Comorbidities (MCC): These diagnoses have a larger impact on a patient’s stay and always requires additional interventions.

• Documentation of Present on Admission (POA)
  – Clear documentation of the presence of diagnoses on admission, is a critical element when determining DRG assignment.
  – If a patient develops one of the specific conditions identified as a hospital acquired conditions or “HAC”, the condition will not be considered a CC or MCC, and will not impact the MS-DRG.
Documenting Conditions

Complications/Comorbidities (CCs)

- Hyponatremia
- Urinary Tract infection
- BMI >40 or <19 (also document clinical diagnosis or condition the corresponds to the abnormal BMI and explains its significance)
- Mild or Moderate Malnutrition
- Acute Blood Loss Anemia
- Hemiparesis
- Chronic Respiratory Failure
- Chronic Kidney Disease or Acute Renal Failure
Documenting Conditions

Major Complications/Comorbidities (MCCs)

- Stage III or IV Pressure Ulcer (POA)
- Acute Respiratory Failure
- Acute Renal Failure with ATN
- Acute Heart Failure (Systolic/Diastolic)
- Encephalopathy
- Severe Protein Calorie Malnutrition
- Brain Death
- Coma
- Cerebral Edema
- Brain Herniation
Background: One Example

Patient admitted for bowel surgery

Post-op, congestive heart failure is detected, cardiologist is consulted

Diuresed, patient does well

If note says:

“Heart Failure”

DRG 331
ELOS 4.0
$15,027

“Systolic Heart Failure”

DRG 330
ELOS 6.8
$22,966

“Acute Systolic Heart Failure”

DRG 329
ELOS 14
$44,849

MS DRG Category: Major Small & Large Bowel Procedures
How Sick Are Your Patients?

• **Not Sick** = No Severity of Illness (SOI) or Risk of Mortality (ROM)

• **Sick** = One or more **CC’s** (Complications/Comorbidities)

• **Very Sick** = One or more **MCC’s** (Major Complications/Comorbidities)
It’s Okay to Hedge Your Bets

For inpatients (not outpatients):
  • Probable
  • Possible
  • Suspected
  • Likely
  • Still (yet) to be ruled out

... or any variation thereof *can be coded!*
Documentation Examples

**PULMONARY:**
Acute hypoxic respiratory failure
Secondary to pulmonary edema and AS vs HCAP

- Intubated on 10/15 after failing bipap

**INFECTION DISEASE:**
HCAP
Worsening consolidation on CXR between 10/14 and 10/15 with auscultation changes concerning for pneumonia. She has been afebrile but with increased WBC on 10/15. Recent admission in September for NSTEMI that was complicated by Cdiff puts her at risk for HCAP.

- Vancomycin 1250mg and dose by level [10/15 - present] - changed to 750 mg on 10/16 after vanc level of 10
- Piperacillin-tazobactam 3.375g Q8h [10/15 - present]
- Respiratory viral panel - negative

**Acute Diarrhea**
Could be secondary to B. Cereus (blood culture from 10/15 positive in 1 of 2 bottles of blood cultures), has a history of C.Diff. Covered on above at

- Started lactobacillus on 10/16
- Continue to monitor output from flex seal

**RENAL:**
AKI on CKD. Stage 2 or 3
Baseline 1.2-1.4, Cre 1.3 on admission. Increased Cr to 1.6 on 10/16, likely secondary to diuresis and/or cardiorenal syndrome.

- Monitor Creatinine daily

**GASTROENTEROLOGY:**
Ulcerative colitis

- Continue prednisone 5mg
- Vedolizumab Q6w due on 10/23 (not currently ordered)

**Tube feeds**
Patient had OG tube placed

- Repeat abdomen xray to check OG placement
- Nutrition consulted for recs

**HEMATOLOGY / ONCOLOGY:**
Anemia, normocytic
Hgb 7.6 on admission, dropped to 7.3 on 10/15, later dropped to 6.8. Type & screen done. Son (DPOAH) signed consent on admission.

- Transfused 1uPRBC on 10/16 after diuresis.
- Continue to monior Hgb
**Documentation Examples**

- **Diagnosis**
  - **Hospital (Problems being addressed during this admission)**
    - **High output ileostomy**
      - **Overview** Monitor, check C diff, fiber waferas and antidiarrheals as appropriate
    - **Hypomagnesemia**
      - **Overview** Monitor, replete < 2.0 as appropriate
    - **Acute blood loss anemia**
      - **Overview** Monitor, transtuse < 7.0 as appropriate, iron supplement at discharge as appropriate
    - **Hyponatremia**
      - **Overview** Monitor, replete < 135 as appropriate
    - **Hypophosphatemia**
      - **Overview** Monitor, replete < 3.0 as appropriate
    - **Acute postoperative pain**
      - **Overview** Monitor, treat with IV/PO pain meds prn
    - **Adjustment disorder with mixed disturbance of emotions and conduct**
      - **Overview** Monitor, resume home meds as appropriate, Psych Nursing and/or Psych consult prn
    - **Crohn's disease of both small and large intestine with fistula**
      - **Overview** Monitor, resume home meds as appropriate, GI consult prn
    - **Depression**
      - **Overview** Monitor, resume home meds as appropriate
    - **Ileostomy status**
      - **Overview** S/p revision, small bowel resection 10/24/17 Monitor, education per enterostomal therapy to:
    - **Severe protein-calorie malnutrition**
      - **Overview** Monitor, RD consult, continue TPN as appropriate
    - **Superior mesenteric vein thrombosis**
      - **Overview** Monitor, resume therapeutic anticoagulation as appropriate
    - **Vitamin D deficiency**
      - **Overview** Resume home meds as appropriate

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**Example #2**
## Documentation Examples

<table>
<thead>
<tr>
<th>Documentation Example</th>
<th>Coding Result</th>
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| Patient admitted with progressing SOB and increased oxygen need. Intubated in ED. History of COPD and home oxygen use and inhalers. Admitted to MICU... | • Shortness of breath  
  • Dependence on oxygen  
  • Ventilatory support, unknown duration  
  • COPD |
| **Query opportunity identified: Respiratory Failure (acute /chronic)**                |                                                    |

<table>
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</tr>
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</table>
| • DM  
  • Moderate Malnutrition  
  • CAD  
  • Hypertension                                                             | None          |

**Diagnoses are only codeable when linked to supporting documentation**
Documenting Malnutrition

- The dietician’s assessment will list a recommended malnutrition diagnosis based on ASPEN criteria. Possible conditions are as follows:
  - Mild (non-severe) malnutrition – First degree (ICD10: E44.1)
  - Moderate (non-severe) malnutrition – Second degree (ICD10: E44.0)
  - Severe protein calorie malnutrition- Third degree (ICD10: E43)

- The malnutrition diagnosis must be documented by the provider, including how the specific type of malnutrition was monitored, evaluated, or treated. The diagnosis cannot be coded without this information.

- The “.malnutritiontext” Epic dot phrase can be used to insert the diagnosis and Present on Admission status from the dietitian consult into your progress notes. However, the provider must still state the malnutrition diagnosis and supporting documentation in their documentation.
What we do as a medical team counts!

Remember M.E.T.: Monitor, Evaluate, Treat

- **Chronic Medical Conditions**
  (Examples: CKD, CHF, DM, HTN, Chronic Respiratory Failure)
  - Did you draw labs that monitor a chronic condition?
  - Did you give a home medication for a chronic condition?
  - Did the patient require more nursing care?
    (Examples: Bariatric, Elderly, Psychiatric cases)
  - Did the patient require a longer length of stay due to a chronic condition?

If you did the work, document it!
Get credit for the work you do!
Discharge Summary

• **Most** important document from a hospital billing perspective
  – Goal is to summarize conditions and include supporting documentation
  – Don’t rush through it to “get it done”

• Include all diagnoses at the time of discharge even if **resolved** or **unconfirmed** but treated, evaluated, or monitored
  – Clarify after testing, any “suspected” diagnoses that are eliminated

• Respond to queries on findings from pathology or autopsy reports
• There should be no conflicting information between providers or services
• New information should not be introduced in the DC summary
Queries from CDI RNs

- **Purpose**: Communication between CDI and Provide to ensure that the most clinically accurate picture of patient conditions in Epic

- **Goal**: Clarify documentation that was inconsistent, lacking specificity, or missing. Provides the LIP an opportunity to respond and add to medical record

- **Query Process**:
  - Initial query to lowest level provider via Epic
  - Escalation after two business days
  - Secondary escalation contacts

- Queries need to be responded to within a total of 4 business days
- “Yes” response requires either update of the record or tell the CDI RN you disagree.

- By law, written queries cannot be leading. Please contact CDI RN’s directly if you have questions
Five Ways to Minimize Query Numbers

1. Complete and accurate documentation the first time can minimize the queries you receive.

2. Specify medical diagnoses when you are able
   - Acuity (i.e. Acute, Chronic, Acute on Chronic)
   - Type (i.e. Systolic or Diastolic)
   - Stages of disease or wounds
   - If it’s a broad diagnosis like “Anemia” be sure to document the cause (i.e. Acute Blood Loss, Dilutional, Chronic Disease Related)

3. Avoid documenting in purely descriptive terms
   (i.e. Elevated, Low, High)

4. Complete procedure documentation in a timely manner

5. When you do receive a query, discuss the documentation requirements with the CDI RN to be certain you understand necessary documentation elements needed for the diagnoses you use.
Documentation Tool Kit
Clinical Documentation Guidelines/Handbook

- Go to The Point, under Top Links find the Clinical Application Web Link
Documentation Tool Kit

- Dot Phrases
- Top 10 Lists for your Department
- See your department’s CDI Nurse for details!

Dot Phrases for Pilot

(.QCKDLIP) CKD
- Include the stage 1-5, ESRD note if patient is receiving dialysis
- Note the cause (i.e. atherosclerosis of renal artery, DM, HTN, Medication)
- AKI and CKD must both be documented separately
- Documenting acute on chronic kidney disease will note code to AKI
• Questions or Comments?